

FIRST REPORT OF INJURY FORM CHECKLIST

COMPLETE THIS FORM ONLY IF MEDICAL TREATMENT WAS PROVIDED BY A PHYSICIAN.

THIS FORM MUST BE COMPLETED BY THE SUPERVISOR, WITH EMPLOYEE INPUT. Please read and use this checklist to ensure that the items on this form are completed correctly:

The supervisor should complete item **1**; items **3-35**; item **41**; item **43**; and item **45**. Some of the items are self-explanatory; others identified below should be completed as stated.

- ◆ All dates should be entered in MM/DD/YYYY format.
- ◆ #6: Be sure to enter last name first and to use given name (no nicknames).
- ◆ #10: Include the **area code** in the home phone number.
- ◆ #12: For occupation, use the employee's **official labor contract title**. No abbreviations.
- ◆ #13: Enter the department title from the "[Department List](#)" provided. If questions, contact Human Resources for assistance.
- ◆ #14: Use the exact hire date (month, day, and year) - this date is the original date of hire with the City of Duluth, not the date hired into the current position. This information should be obtained from the Payroll office.
- ◆ For all phone numbers requested, include the **area code**.
- ◆ For wage information (Items #15 & 16), contact Payroll with the employee's name and date of injury and requesting wage information. **The wage information must include the average pay for the 26 weeks immediately preceding the date of injury, including overtime**; it is not sufficient to use the wage listed in the contract. Also, be sure to include any information regarding a second income in #20.
- ◆ #22 & #23: Be sure to put the proper info in each section. A description of **how** the injury occurred should go in #22 (what the employee was doing immediately before the incident and what happened). Information about **what part** of the body was injured and what the injury was should go in #23.
- ◆ #26: Enter the date the treating physician authorizes lost time in writing. If the physician does not take the employee off work, this line and #29 should be left blank. **Time off for medical treatment is not considered lost time and will be paid as regular time if the employee is scheduled to work at the time of the treatment.**
- ◆ #30: Complete this line if the physician has authorized return to work with or without restrictions.
- ◆ #32: List the physician who was seen for this injury. **DO NOT LIST THE EMPLOYEE'S PRIMARY CARE PHYSICIAN, unless he/she actually provided treatment for this work-related injury/illness.**
- ◆ #41: Enter the name/phone # of the injured employee's supervisor. (The actual supervisor's name should be entered here, even if another supervisor is completing the form.)
- ◆ #43 & #45: Don't forget to complete these two; they are often missed.